Strategic Plan 2007-2011

Health and Recovery Services Administration

Washington State
Department of Social
& Health Services

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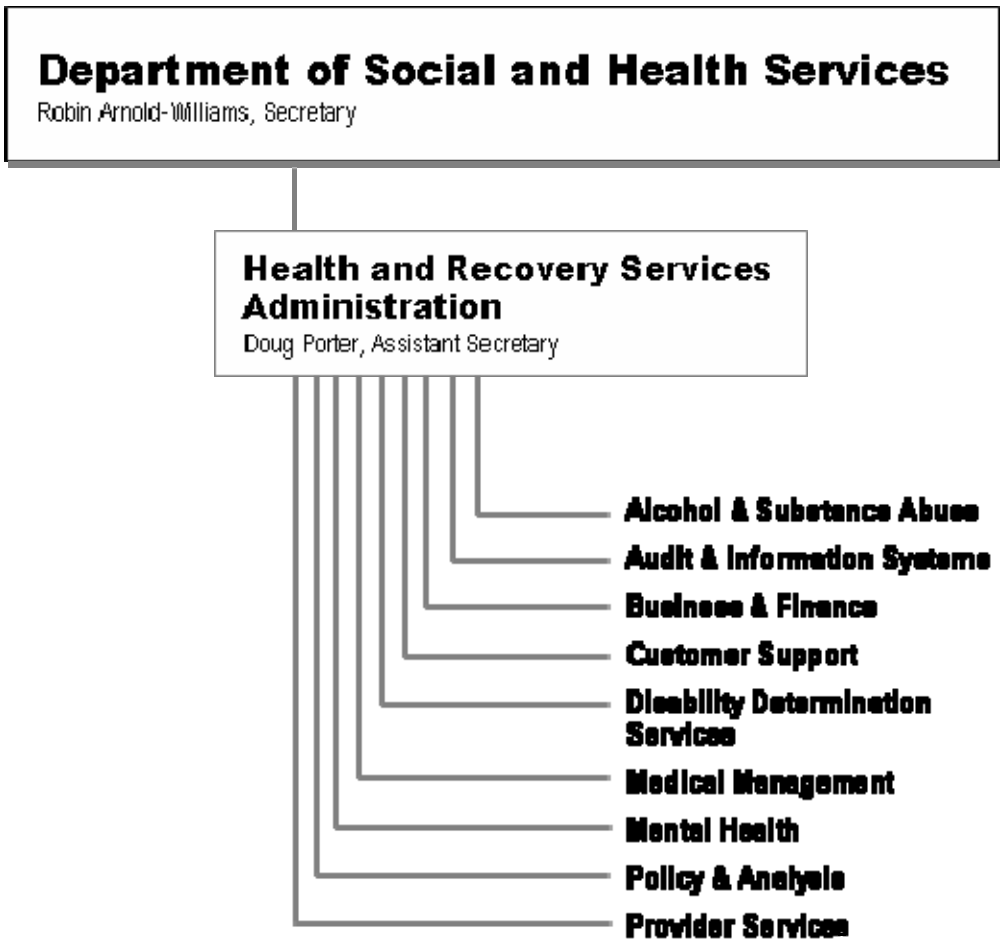

The Purpose of This Document
This strategic plan communicates how we will advance our mission and goals in a changing environment and meet our future challenges, so that we can better serve the most vulnerable populations in Washington State. This document is a road map that guides the business policies and improvement strategies for our organization, employees and partners.

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Executive Summary

This strategic plan attempts to lay out the vision and goals of the new Health and Recovery Services Administration (HRSA) in a comprehensive and cohesive manner. Overall, HRSA's long-term strategies are a product of three things:

1. *Our continuing drive for fiscal integrity and quality services*
2. *The goals set for us by leadership and policymakers*
3. *And an evidence-based, recovery-directed philosophy of care.*

I. The Health and Recovery Services Administration will continue its efforts over the next five years to become a more accountable organization and a more prudent purchaser of health-related services. We need to be a more nimble, flexible organization, one that will be better equipped to face ever-tighter fiscal constraints, new state and federal mandates, and the continuing challenge of containing ever-increasing health-care costs.

- Prior to July 2005, the Medical Assistance Administration (MAA) was a distinct entity with a primary focus on providing access to and payment for acute medical care for low-income individuals. On July 1, 2005, MAA was realigned as a new administration -- the Health and Recovery Services Administration (HRSA), adding the Mental Health Division (MHD) and the Division of Alcohol and Substance Abuse (DASA) to its existing medical care components.

- Under the realignment, HRSA is developing new policy and integrated treatment approaches for physical health, mental health, substance abuse and gambling addiction. The new administration will also address administrative efficiencies under a shared services model. Common administrative services, such as contracting, personnel, information and financial services will be integrated gradually to serve the entire administration.

- The benefits envisioned from the realignment will be an integration of many levels of care, improved quality of care, and enhanced fiscal integrity. The same programs that benefit clients will identify and reward providers for economical and effective treatments, better contain agency costs, and increase taxpayers' protection from the cycles of health-care inflation.

II. The coming era at the Department of Social and Health Services (DSHS) will be dominated by the new ProviderOne billing and payment system. ProviderOne will be a quantum-leap improvement over the current legacy Medicaid Management Information System (MMIS) and will dramatically expand payer responsibilities within DSHS.

- The idea behind ProviderOne is to link state-of-the art thinking to the technology of the future. Conceptually, ProviderOne will be able to handle tasks better and faster than before, with built-in flexibility and capacity for change as it is needed.

- The first phase of ProviderOne, culminating in 2007, will duplicate and improve on the current functions of the legacy MMIS, providing additional audit capacities,

eliminating errors and overpayments, and enhancing the decision-support systems within the overall Medicaid program.

- The second phase of ProviderOne, targeted for 2009, will expand the system's payer responsibilities to a broad range of health and social service providers' claims. By the end of the decade, ProviderOne will be the central DSHS payer system, bringing a new logic and expanded capacity to the agency's overall provider payment functions, including non-Medicaid programs.

III. Over the next decade, HRSA also will work with other government health care programs to implement policymakers' vision expanding coverage, increasing utilization of evidence-based therapies, and maintaining Washington State's tradition as a state in the front ranks of innovative and cost-effective health care programs. Governor Chris Gregoire has set an ambitious health care agenda for Washington State, an agenda that begins with a conviction we can do more with our resources and become a healthier state in the process.

- One of the Governor's primary goals is to see all of the state's children insured by 2010. State medical assistance programs currently cover one in every three Washington children, but approximately one in 10 children still go without health care. The Medicaid program will be an integral part of the effort to bring health care to every Washington child.

- The same energy can drive improvements in care, with a continuing focus on evidence-based treatment – health care that works. In addition, Washington State's Medicaid program will continue its pioneering work in disease management and coordinated care, zeroing in on the five percent of its clients who are responsible for half of our state's Medicaid costs. In addition, Medicaid needs to become more transparent by putting helpful information in clients' hands, assisting them in making good decisions about prevention and continuing care.

- Prevention has been the stepchild of Medicaid, which has been focused on treatment since its birth in the mid-1960s. But health care today can no longer look past the root cause and aggravation of serious illness and chronic conditions. The future of effective health care depends on new strategies of prevention and recovery – maintaining good health when we can, and when we cannot, pursuing those treatments that will restore our lifestyle, our well being and our future.

Douglas Porter
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Chapter 1 ● Our Guiding Directions

MISSION

The Health & Recovery Services Administration provides access to quality health care for Washington's most vulnerable residents.

VISION

Promoting a healthier Washington

GUIDING PRINCIPLES

- HRSA strives to be a prudent purchaser: HRSA pushes for higher quality, better outcomes and cost-efficiencies.
- HRSA is accountable: HRSA analyzes its decisions and outcomes in a meaningful way and takes responsibility for them.
- HRSA manages its programs well: HRSA provides expertise and is the best and fastest source of information about its own programs.
- HRSA works to be more inclusive: HRSA constantly seeks cross-divisional, cross-agency and external perspectives.
- HRSA takes risks to improve: HRSA is innovative and does not hesitate to challenge the status quo.
- HRSA values good decisions: HRSA strives for balanced, timely, informed and practical judgment.
- HRSA is open and honest: Good communication builds trust.
- HRSA values and supports the staff: Reward good work and provide opportunity.
- HRSA strives for fairness and consistency: HRSA policies are documented and apply to all.
- HRSA takes pride in providing good, culturally competent customer service: HRSA is committed to its clients' needs and to the providers who furnish health-care services.

PRIORITIES OF GOVERNMENT

HRSA strives to improve the health of Washington citizens by providing access to quality care for all eligible clients. Health care services include not only treatment for acute physical conditions, but inpatient and outpatient services for mental health and substance abuse.

The Administration is expanding chemical dependency treatment to 42 percent of Medicaid-eligible adults needing treatment by the end of SFY 2007, as well as low-income youth. The treatment expansion is based on previous data indicating that the timely provision of quality chemical dependency treatment services results in healthier clients and lower Medicaid-paid health-related expenses.

The administration helps improve the safety of people and property by providing prevention, intervention and treatment for alcohol, drug and gambling addictions. These services also help keep children in school.

HRSA has implemented policies to reduce the rate of uninsured citizens in our state, particularly for children. While the department actively verifies income eligibility for prospective and current clients, the decision was made to lengthen the span of eligibility for children and allow them access to care continuously for 12 months. HRSA is also implementing the Children's Health Program for non-citizens within limited funding. This will provide care for as many as 14,000 children as of October 2006.

HRSA embraces the value of consumer and family participation in the development of mental health policy, planning and service delivery. Embedded in this value is support for caregiver/peer run services and supports and provision of services in the least restrictive environment possible. Research has shown that caregiver/peer run services are effective, low cost adjuncts to professional services that can reduce the use of inpatient and other high cost services.

Chapter 2 ● The People We Serve

INTRODUCTION

Currently, the State of Washington has approximately 6,000,000 residents, and that is expected to grow by one to two percent per year. At the same time, there are over one million clients eligible to receive services from HRSA – one in six residents.

- One in three children
- Four in ten pregnant women
- One in ten senior citizens

In SFY 2005, more than 975,000 clients were eligible for medical assistance services each month.

- 115,000 women were eligible to receive only family planning services
- Approximately 55 percent of total clients were children
- Forty-nine percent of total clients, 475,000, were in managed care
- Over 70 percent of children were in managed care

In SFY 2005, 29,105 adults and 5,639 adolescents ages 12-17 received chemical dependency treatment.

In SFY 2005, 124,250 people –approximately 93,000 of whom were covered by Medicaid - utilized mental health services in community outpatient settings. In addition 8,600 people received services in community hospitals, and 2982 people received inpatient services from the state hospitals.

By far, the largest funding source for HRSA is Title XIX, Medicaid.

- Over 95 percent of HRSA's clients receive services paid through Medicaid
- Medicaid pays for over 40 percent of the births in Washington State each year

Clients are categorically eligible for Medicaid due to income, age and/or health status (e.g. disability or pregnancy). The major client categories of eligibility for health-related services are:

Categorically Needy (CN) Medicaid: This is a mandatory coverage provided to individuals who meet specific income criteria set by federal and state rules.

Medically Needy (MN) Medicaid: These clients are primarily elderly and disabled and must also meet set income guidelines, but in cases where their income exceeds the limit, they can share the cost of their health care by spending enough on services to bring their income within the guidelines. This is called "spend-down."

State Children's Health Insurance Program (SCHIP): SCHIP is funded on a two-thirds federal/one-third state basis and covers children whose families have incomes between 201 and 250 percent of the Federal Poverty Level (FPL).

Refugee Assistance: While federal Medicaid funds are generally only available to U.S. citizens, certified refugees are exempted and covered.

Medical Care Services (MCS): This program involves only state funds and covers incapacitated individuals not eligible for Medicaid. Most are classified as General

Assistance-Unemployable (GAU). GAU clients are physically and/or mentally incapacitated and unemployable for more than 90 days. ADATSA clients are also eligible due to incapacity from drug or alcohol abuse. Coverage is comparable to Medicaid, although there are some limitations.

DESCRIPTION OF SERVICES

Medicaid clients receive health-care services either through enrollment in the Healthy Options managed care program, managed care pilot projects for adults, or on a fee-for-service basis. Current caseload is divided about 50-50 between the two different delivery systems. For Healthy Options, MAA contracts with licensed health insurance carriers to provide a defined set of services to enrolled members– primarily clients eligible to receive public assistance under the WorkFirst program, low-income pregnant women and low-income children.

HRSA has several small managed care projects that serve elderly and disabled adults. There are also a number of Native American tribes that provide primary care case management to their members

Fee-for-service care is delivered by licensed or certified health care providers who have a contract with DSHS to serve our clients. The fee-for-service program covers services to elderly and disabled Supplemental Security Income (SSI) clients, clients exempted from Healthy Options or in state-administered programs, as well as wrap-around Medicaid services not covered by managed care plans.

HRSA provides access to all medical and mental health services required by federal law, including inpatient and outpatient hospital care, physician care (including psychiatrists), lab, x-ray, family planning, pregnancy-related services, and all necessary screening and treatment for children under age 21. The state also provides many optional services allowed under Medicaid such as prescription drugs, dental, vision, case management, psychologists and therapies.

The types and level of medical or mental health care may depend on income level, age, or client eligibility status. For instance, clients on General Assistance Unemployable (GAU), a state-funded program, receive limited mental health care; clients on the Take Charge family planning waiver program receive only family planning services.

The administration intends to focus more on prevention and recovery in the next five years however DASA has a long and successful history with these modalities. DASA's prevention program covers all segments of the population at potential risk for drug and alcohol misuse and abuse. The primary focus is on children who have not yet begun use or are still only experimenting.

DASA provides a range of intervention services**.** DASA supports county-based detoxification centers across the state. With funding from a five-year federal grant, DASA is implementing the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program. Clients are intercepted and referred to community-based chemical dependency treatment programs as appropriate. DASA is also implementing an Access to Recovery (ATR) program to provide social service intervention to individuals and families in crisis. In SFY 2005, 11,749 individuals received ATR services.

Generally, individuals (both adults and youth) assessed as in need of chemical dependency treatment, whose incomes are below 200% of the federal poverty level and who do not have access to treatment through health insurance mechanisms, qualify for DASA-funded treatment.

Beginning in the 2005-2007 biennium, funds were shifted within DSHS to expand chemical dependency treatment to 42 percent of Medicaid-eligible adults needing treatment by the end of SFY 2007, as well as youth under 200 percent of the federal poverty level. The treatment expansion is based on previous data indicating that the timely provision of quality chemical dependency treatment services results in healthier clients and lower Medicaid-paid medical expenses.

As a result of legislation enacted in 2005, DASA is implementing integrated crisis response/secure detoxification programs in Pierce County and in the five North Sound counties for individuals who are gravely disabled or present likelihood of serious harm to self or others as a result of substance abuse.

MHD contracts with Regional Support Networks (RSNs) to provide mental health services mandated by state and federal statutes. Under the Federal managed care 1915 (b) Medicaid waiver, RSNs provide an array of mental health services to Medicaid recipients.

State funded services are available to all low income persons in the state, and include community support, as well as employment and residential services for persons meeting statutorily defined categories.

RSNs administer the involuntary treatment program and the crisis response system for the citizens of the state of Washington in their service area. These crisis services are available to all citizens, regardless of income.

MHD is also implementing several new services in partnership with RSNs. Services for individuals transitioning from county jails into the community mental health programs, Multi-Dimensional Treatment Foster Care as an alternative to inpatient hospitalization for children, and the development of Assertive Community Treatment Teams across the state are all evidence-based programs the MHD is infusing into the community mental health system.

MHD owns and operates two adult psychiatric hospitals and one psychiatric hospital for children. These hospitals provide care for approximately 1,300 adults and 47 children each day. Recent legal settlements have required expansion of the state hospitals. Western State Hospital has opened one ward and will need to open three additional wards over the next 16 months. Eastern State Hospital will need to open one ward over the next 16 months.

MHD also holds contracts for the operation of three children's long-term inpatient (CLIP) programs for 44 children statewide. MHD plans to expand the capacity for children's acute and long-term inpatient care across the state. Within the adult hospitals, there are two systems of care: civil and forensic (legal). Patients enter the civil wards of the hospital through involuntary civil commitment. Voluntary admissions are not common due to lack of available capacity. Patients enter forensic wards through the criminal justice system. Services include psychiatric evaluations, restoration of competency to stand trial, and care of those found not guilty by reason of insanity. As the demand for forensic evaluations and treatment increases MHD plans to request the development of additional forensic wards at both Western and Eastern State Hospital.

Chapter 3 ● Appraisal of External Environment

POTENTIAL CHANGES IN ECONOMY THAT CAN AFFECT CLIENTS' NEEDS

One of the largest concerns, both in this state and nationally, is access to affordable health care. Inflationary pressure has forced smaller employers to shed coverage for employees and their dependents, larger employers to reduce benefits or lay off workers to maintain current benefit levels, and forced cities and counties to change benefit structures for new employees. Retirees are forced to return to work to attain coverage or to otherwise pay for health care costs. Health insurance, which is considered by many to be a basic necessity, is becoming unaffordable but the cost to the health care industry for the growing number of uninsured individuals is unsustainable.

Without fundamental changes in the health care service delivery and payment system in general, Medicaid and state-funded medical, mental health and substance abuse prevention/treatment programs will see growth in caseloads and costs in future biennia.

TRENDS IN DEMOGRAPHIC AND CUSTOMER CHARACTERISTICS

Medicaid enrollments in Washington State grew rapidly throughout the 1990s and 2000-2002, but the trend has leveled since then. The largest segment of the Medicaid population, children, is expected to grow by an average of 7.5 percent per year in the 05-07 biennium, 2.2 percent in 07-09 and approximately 2 percent in 09-11.

The Medicare prescription drug program started on January 1, 2006. As a result of this new coverage, there has been a substantial reduction in the number of clients eligible for the Medically Needy program. The long-term impacts to caseload are unknown. However, it should be noted that the State will continue to pay for almost half of the cost of prescription drugs for dual-eligible clients under the Medicare Part D funding formula. And, effective February 21, 2006, HRSA is temporarily paying Part D co-payments ($1-$5 per prescription) for all dual-eligible clients.

The September 2005 Superior Court rulings in the Pierce County lawsuit significantly increased the State's challenges to effectively manage RSN utilization of state hospital beds. Western State Hospital has opened one ward and will need to open three additional wards over the next 16 months. Eastern State Hospital will need to open one ward over the next 16 months. In addition to the creation of new wards MHD will be creating eight PACT teams across the state to provide high intensity and hospital diversion services in the community.

ACTIVITIES LINK TO MAJOR PARTNERS

HRSA has embarked on a number of collaborative activities designed to increase the quality of care, improve health outcomes, and ultimately achieve some level of savings so that we might sustain our commitment to serve an ever-increasing number of clients.

The administration works with Labor & Industries (L&I) and the Health Care Authority (HCA) to develop evidence-based practices across all three agencies. Each agency has its area or areas of potential over-use of services, but all three agencies benefit from the decisions made. For HRSA, one of the first decisions made under these criteria was not

to cover bariatric surgery without first determining whether the client would gain long-term health benefits from the procedure.

In January 2006, Governor Gregoire issued a directive to the Department of Health (DOH) and DSHS to collaborate on an initiative to improve chronic illness care in Washington State. The agencies are expected to make recommendations for the 2007-09 budget and develop a new patient-centered model of disease management. Also, the Governor directed all state agencies to cooperate with DOH and HCA on an employee wellness initiative.

In addition, HRSA is partnering with other groups such as the Washington Health Care Forum, in an effort to streamline and simplify the administrative burden on our major stakeholders.

HRSA is also the lead administration in the Medicaid Integration Partnership, an effort to bring together all of the Medicaid funding streams in DSHS and create a new delivery model that is client-centered and efficient.

DASA facilitates a collaboration of judges, prosecutors, law enforcement professionals, county and tribal social service agencies, and community-based chemical dependency treatment providers in providing treatment alternatives to incarceration.

DASA is working with a full range of state and local agencies, treatment providers, and youth advocates to enhance the adolescent substance abuse treatment system. The improved infrastructure, with a new statewide leadership council, will foster cross-system planning, needs assessment, knowledge and resource sharing, and integrated training and education regarding evidence-based practices.

A consortium of DSHS divisions works with the Department of Health and local service agencies to provide services to substance-abusing pregnant and parenting women and children ages birth-to-three, in three project sites around the State.

In 2004, MHD was the focus of a Mental Health Task Force co-sponsored by the Legislature and DSHS. The Task Force recommendations resulted in many cross-system collaborations, including integrated treatment for individuals with mental health and substance abuse problems, partnerships with Economic Services to improve clients' ability to enroll in benefits programs, the implementation of evidence based practice models, and partnership with DVR regarding clubhouse based employment programs. The Children's Mental Health Initiative is a partnership between MHD, JRA and CA to look at improving the consistency and integration of mental health services for children with serious mental health needs. CMHI is currently moving forward with implementation of 5 evidence based practices for children. The goal is for all 5 services to be available to all children in need across the 3 partner agencies. Multi-Dimensional Treatment Foster Care is the first practice that MHD is implementing.

In September 2005, SAMHSA awarded $92.5 million to seven states, including Washington State, for Mental Health Transformation State Incentive Grants (MHT SIGs). These grants provide planning funds to integrate and transform mental health service delivery across 17 state agencies. The promise of these grants is an integrated, efficient service delivery system that removes funding and service silos and allows consumers and families to purchase the services that will best meet their needs. The grants also champion mental health delivery systems that are focused on building resilience and facilitating recovery, rather than a system of maintenance and continuing entitlement.

STAKEHOLDER INPUT

In November and December 2005, the Health and Recovery Services Administration conducted an e-mail survey of providers, clients, stakeholders and vendors – soliciting their opinions on long-range issues facing HRSA's programs.

The survey – which drew responses from 266 providers, 79 client/family members, 58 self-described stakeholders, and 41 vendors/suppliers – showed substantial agreement that the administration's first concern should be improving access to care and that its key strategy for dealing with limited resources should be to increase preventive services.

Overall, respondents were evenly divided after their first choice. Education and prevention programs, incentives to encourage healthy behaviors, and evidence-based practices were all rated a poor second to access initiatives.

Dealing with limited resources: The respondents were less enthusiastic about options like reducing caseloads, cutting optional benefits or reducing the benefits package. Clients and their families voted heavily in favor of individual comments, many of them suggesting ways to avoid the limited-resource premise.

Cross-section of response: Overall, the mix of respondents reflected a broad cross-section of HRSA services – 15 percent had a connection with the state psychiatric hospitals, 20 percent dealt directly with pharmacy; 28 percent dealt with substance-abuse treatments, and 52 percent listed a connection with community mental health programs. (The latter's strong showing may have been influenced by a current RFQ process that the RSNs are involved in and the restructuring of the DSHS infrastructure for Mental Health.)

Medicaid connections: About 51 percent of the respondents said they dealt with fee-for-service Medicaid services; another 40 percent said the same about Healthy Options, the managed-care version of Medicaid.

HRSA's performance: The respondents rated HRSA's performance as average, at best. Overall, 34 percent called the agency average, 27 percent said it "needs work," and 10 percent described it as poor. Only 29 percent rated the agency as good or excellent.

Improving provider relations: Respondents in the different categories also agreed that the best way to expand HRSA's partnerships with health-care providers would be to let them participate in decision-making. The No. 2 response, increase provider rates, also drew broad support from all categories of respondents.

Other comments: Most impressively, those who responded to the survey also took the time to frame individual and sometimes lengthy comments about the agency, its priorities and how it should strategize for the future. Those comments will be posted on the agency's Web site when the strategic plan is posted.

Unrelated to the recent HRSA survey, the Citizens Advisory Council on Alcoholism and Drug Addiction is charged with advising and recommending to DSHS rules, policies, and programs that will benefit individuals and their families with alcoholism/addictions; families and individuals in high-risk environments; and the larger community.

The Washington State Mental Health Planning Advisory Council (MHPAC), mandated by Washington and Federal Law, is charged with advising MHD regarding the Division's policies, plans and budgets and makes recommendations to assure a strong link between government decisions and consumer, family and advocate needs and concerns. MHPAC's subcommittees include groups dedicated to the needs and concerns of children, elders, ethnic minorities, and sexual minorities.

MHD staff meets regularly with RSN administrators and assures there is representation from the RSNs on stakeholder committees. MHD also meets with the Washington Community Mental Health Council, a group representing community mental health provider agencies.

The TXIX Advisory Council provided valuable input, which has been incorporated in the section in this document entitled "Closing the Performance Gaps." Full text of their comments is in Appendix 4.

FUTURE CHALLENGES AND OPPORTUNITIES

Over the next decade, HRSA and other government health-care programs must expect to be challenged by various opportunities and risks. Among them:

Federal cutbacks: Federal policymakers are expected to continue their efforts to reduce participation in the Medicaid program. This effort began in reasonable attempts to increase management opportunities in the tightly budgeted recession of 2000-2003. In coming years, states will likely be pressured to accept block-grant funding, more rigorous accounting and auditing, and continuing actuarial attempts to limit federal spending.

In addition, under the Deficit Reduction Act of 2005, states must verify the citizenship of current Medicaid enrollees and applicants. This has a serious administrative impact throughout the department.

Sustainable Medicaid: Health care's share of the state's budget increased from 22 percent in 2000 to 28 percent today – a trend that drains more than $750 million a year from priorities like education, criminal justice and public safety. Medical inflation continues to increase every year, although at a slower rate.

Improved quality of care: Health care overall must look to new tools like evidence-based decision making, improved definitions of medical necessity, and better decision-support data. Better information systems will help, but they will need to be achieved in an era of downward financial pressures.

Mental health services: DSHS is spearheading a broad campaign to upgrade mental health services and the delivery system across all government programs. The State received a SAHMSA grant to "transform" the mental health delivery system by increasing consumer-driven services and the use of evidence-based mental health care. Legislative mandates also define a set of new standards of performance for the RSNs. Those RSNs that are unable to meet the new standards may be replaced by entities better suited to deliver high quality mental health services.

Treatment and recovery: A five-year transformational grant project called "Partnerships for Recovery and Resiliency" and funded by a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) will develop an

inventory of state services and mental health needs, then will work on ways in which state mental health delivery systems can be upgraded and to serve as models for other states.

Prevention and care coordination: Medicaid will have to look beyond customary treatments, bringing a sharpened sense of wellness and healthy choices to its clients. Medicaid must be a leader in devising prevention strategies and stepping up its promotion, mirroring the success of chemical dependency and drug abuse prevention and treatment programs.

The administration must deal with chronic medical conditions using care coordination and managed care models. HRSA must build on its success in managing the care of clients with congestive heart failure, diabetes, asthma, and kidney disease. Currently, approximately five percent of clients account for 50 percent of state-purchased health care expenditures.

In addition, the five-year federal Strategic Prevention Framework State Incentive Grant (SPF/SIG) provides DASA with the opportunity to develop and implement a data-drive state prevention plan in collaboration with all state agencies that administer substance abuse prevention services. The plan will be implemented in 12 community sites across the state.

Provider rates: Medicaid provider rates are at the bottom of the health-care industry and are approaching a break point in which prospective doctors and hospitals will openly seek alternatives to Medicaid contracts. Washington State must seize any available opportunity to boost provider rates and retain strong primary and specialist representation in provider ranks. Thanks to an increase in funding from the Legislature, MHD will be able to increase capitation rates paid to RSNs in the coming year. However, rates for consumers who do not have Medicaid continue to lag behind. Crisis and involuntary hospitalization costs rise annually, and provider rates need to be tied to economic forecasts and projections.

Technology: Effective screens are needed in an academic research setting so that the state can rate medical technology before widespread adoption. This offers a leadership role for the state within the health-care industry, providing strong support for evidence-based decision-making. In addition, many implementation issues for evidence based care have been studied. Technological models are in place that can reduce implementation burdens for providers and consumers, such as telemedicine and electronic health records.

Health disparities: Washington State government can be a leader in the effort to identify racial/ethnic disparities within the health-care system and develop interventions to better protect cultural minorities within the health-care system. Projects range from the higher incidence of diseases and late-stage diagnoses among minority populations to the fundamental skills of cultural competence – training staff to investigate these issues in a sensitive manner, recruiting providers from the minority communities, working with minority populations to better reflect views inside their community, and finding ways to expand minority access to effective providers.

Intervention: With the receipt of a five-year federal grant, DASA is working to engage individuals in emergency department settings to determine whether individuals are in need of chemical dependency treatment or, alternatively, whether brief interventions or brief therapy to interrupt substance misuse can be effective in reducing risks of future

re-injury or hospitalization. The possibilities for intervening in the lives of substance abusers before they become chemically dependent hold out great promise for an agency dedicated to ensuring a healthier population.

The implementation of Assertive Community Treatment and other evidence based practices in the mental health community should result in a shift of services and funds from the State Hospitals to RSNs and community based services. The ability to serve consumers in their home communities increases community involvement in the client, improving both the quality and the outcome of treatment.

Expanding capacity: Research has demonstrated the value of public funded chemical dependency treatment in reducing criminal behavior and acute medical/psychiatric costs. As funds become available to expand treatment access, it is becoming increasingly difficult to attract contractors to provide residential treatment services. Contractors must make a substantial investment in facilities that meet Department of Health and DASA standards, in addition to operating costs, in order to obtain a state contract. Community resistance to siting such facilities exacerbates these problems. Gaining community and local government support for new facilities may subject contractors to costly delays.

One approach to dealing with these difficulties would be for DASA to acquire buildings to be used by alcohol and drug treatment programs. These facilities would be owned by DSHS but program operations would be contracted out to independent service providers. In addition, a grants program to assist non-profit providers in renovating existing facilities would be useful to ensure ongoing quality.

MHD will be expanding capacity at the state hospitals, however we also plan to expand community based programs through increased use of evidence based practices that improve client outcomes and ultimately reduce the need for inpatient services. MHD plans that this combination of strategies will eventually result in a downsizing of the state hospitals and an increase in evidence based care in the community.

Chapter 4 • Goals, Objectives, Strategies and Performance Measures

Goal: IMPROVE HEALTH CARE QUALITY AND ACCESS		
Objectives	**Strategies**	**Measures**
Provide integrated health are services that are holistic, comprehensive and cost effective	• Continue to collaborate with other partners to evaluate WMIP and MMIS	• Number of clients served in WMIP and MMIP
Increase the number of children with health coverage	• Maintain the current policy of 12 months continuous eligibility once a child is deemed eligible for medical care. • Expand Employer-Sponsored Insurance pilot project to maximize existing available coverage for children on Medicaid & SCHIP • Expand enrollment in the Children's Health Program (CHP) to appropriated levels • Close the gap on vaccine coverage • Implement the federal Family Opportunity Act	• Cumulative fiscal year average monthly enrollment of children in medical assistance programs • Number of children enrolled in Employer Sponsored Insurance program • Number of children enrolled in CHP • Immunization rates for 2 year olds in managed care plans Activities: H056 Mandatory Medicaid for Children & Families, H057 Medicaid for Optional Children, H089 SCHIP
Deliver services in community settings when possible and eliminate disparities in mental health services	• Increase community services for people with mental illness and long-term care needs • Improve formal delivery agreements with other programs to strengthen discharge planning from inpatient settings for multi-system customers • Provide newly discharged consumers with extensive community reintegration and resiliency supports to ensure their successful integration into the community • Increase community hospital non-Medicaid psychiatric payment rates to 70% of Medicaid rates • Add the RSN non-Medicaid caseload to forecasted eligibles • Implement other alternatives for children to state institutionalization • Move minority and tribal promising practices to evidence based practices • Make staff aware of intra- and inter-agency agreements and ensure periodic review. • Develop clear discharge criteria for the state hospitals which require written "acceptance of transfer of responsibility" by community providers, ensuring timely continuity of care. • Provide youth discharging from state hospitals and facilities, and their families/care providers with extensive community reintegration and resilience supports to decrease the likelihood of hospital readmission. • Continue to develop and refine Level of Care Standards for all consumers that highlight services designed to promote autonomy in order to foster less dependence upon the publicly funded system of care.	• Reduce the use of restraint and seclusion at ESH, WSH and CSTC • Increase the percentage of consumers who are seen in the mental health system within seven days following discharge form inpatient services • Increase the number of consumers showing positive outcomes in the areas of: employment, independent living, social connectedness, substance use. • Increase the number of consumers receiving an EBP. Activities: C017 MH Services – Medicaid Managed Care, C018 MH Services – Non-Medicaid Recipients, C069 MH Services – Other Community Programs, C069 MH Services – Child Study & Treatment Center, C063 MH Services – State Psychiatric Hospitals

Goal: IMPROVE HEALTH CARE QUALITY AND ACCESS (cont)		
Objectives	**Strategies**	**Measures**
Increase access to medical coverage and services	• Integrate services to foster care children among HRSA divisions • Increase outpatient chemical dependency treatment rates, outpatient mental health rates, and dental rates paid to providers of care to both adults and children • Sustain or increase provider participation • Implement One Health Port • Spend down to 100% FPL for Medically Needy Aged, Blind and Disabled • Continue to cover Medicare Part D co-payments for dual eligible clients	• Number of providers delivering specific services (dental, physician) to Medicaid clients • Implement funded, targeted program rate increases Activities: H056 Mandatory Medicaid for Children & Families H057 Medicaid for Optional Children H089 SCHIP

Goal: IMPROVE TREATMENT FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY		
Objectives	**Strategies**	**Measures**
Respond effectively to treatment needs of children and youth	• Implement evidenced-based Children's Mental Health Pilot Program to provide evidence-based mental health services to children • Seek funding for and establish a Youth Level III Secure facility to treat substance-abusing youth in need of a high level of security and highly intensive chemical dependency treatment. • Increase support for parents of children and youth with mental health issues • Add a new 48 bed children's facility at the state hospital – CSTC model (Capital)	• Funding secured for facility
Provide mental health care that's consumer and caregiver driven	• Involve consumers, their families, caregivers, and advocates in all program design and planning of the recovery process • Disseminate information on SSDI, SSI, Ticket to Work, Medicaid buy-in, and other employment opportunities for adult consumers within the service and consumer communities. • Provide training on client centered treatment planning at all state hospitals • Provide training to consumers in Wellness Recovery Action Planning (WRAP). • Expand peer counseling training and programs to support consumers across the life span • Develop and train consumers as mental health system advocates expanding consumer participation in development, planning and operations of the mental health system. • Increase the role of consumers and families in quality management activities within MHD, state hospitals, RSNs, Community Mental Health Centers (CMHC), and CLIP. • Provide mentoring to consumers, families and client/ consumer committees and stakeholder meetings to increase consumer/care caregiver presence on RSN and state hospital governing bodies and other oversight and policy groups.	• Percent of clients receiving peer support or clubhouse activities • Percentage of consumers and caregivers who reported that they directed their treatment plan • Increase the percentage of consumers reporting they are treated with respect, dignity and compassion by their treatment providers. • Increase the number of consumers and family members who serve on committees and stakeholder groups. Activities: C018, Mental Health Services – Non-Medicaid Recipients C069, Mental Health Services – Other Community Programs C074, Mental Health Services – Innovative Service Delivery Projects

Goal: IMPROVE TREATMENT FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY		
Objectives	**Strategies**	**Measures**
Reduce the number of untreated persons in need of chemical dependency treatment	• Implement treatment expansion contracts, providing a continuum of alcohol and drug treatment services for aged, blind, disabled, low-income (GAU, GAX), and youth clients • Implement crisis response/secure detoxification and intensive case management pilot programs to assist individuals in crisis or gravely disabled as a result of substance abuse • Provide additional technical assistance to providers to expand capacity • Expand the number of emergency departments participating in the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program, providing interventions and treatment referrals to individuals in need of substance abuse-related services	• The increase in the number of aged, blind, disabled, low-income, and youth clients who receive chemical dependency treatment • The number of appropriate detentions in secure detox facilities, and the number of individuals referred from those facilities that enter chemical dependency treatment within the subsequent 30 days G085, Residential Drug and Alcohol Treatment Services
Develop a strong prevention and treatment network	• Implement research-based prevention programs in schools and measure the anticipated reduction in substance use • Collect data from prevention programs that will measure the anticipated reduction in substance use, and risk for use/abuse. • Implement a program for the prevention and treatment of problem and pathological gambling, including the training of professionals in the identification and treatment of problem gamblers • Provide training to mental health and chemical dependency professionals in order for them to gain knowledge and skills in the treatment of problem gamblers. • Expand the number of fee-for-service mental health providers and the GAU mental health benefit	• Percent of DASA prevention programs that are best practices as defined by the Western Center for the Application of Prevention Technologies • Number of prevention activities (target: four) during each biennium to disseminate a responsible gaming message and to target high-risk populations • A minimum of 60 hours of training for potential problem gambling treatment providers will be sponsored, co-sponsored, supported, or promoted by DASA during each biennium. • DASA will contract with a minimum of one treatment provider in each of six regions to provide treatment to problem and pathological gamblers during each biennium. • Demonstrate the association between science-based prevention programming and student achievement Activity: G008 Chemical Dependency Prevention Services

Goal: IMPROVE CHILDREN'S SAFETY AND WELLBEING		
Objectives	**Strategies**	**Measures**
Reduce underage drinking and youth marijuana use and the public health problems associated with them	• Enhance funding for communities and schools to facilitate the use of evidence-based practices to prevent and reduce underage drinking and youth marijuana use	• Increase number of high-risk communities and youth receiving evidence-based services to reduce underage drinking and youth marijuana use Activities: G008 Chemical Dependency Prevention Services

Goal: IMPROVE LONG-TERM CARE		
Objectives	**Strategies**	**Measures**
Improve public and individual safety	• Expand safety program at CSTC • Implement client safety, no-lift policy under HB 1672 • Install Nora Flooring in the geriatric ward at WSH	• Reduction in on-the-job injuries in state facilities Activities: C063 MH Services – State Psychiatric Hospitals

Goal: INCREASE EMPLOYMENT AND SELF-SUFFICIENCY		
Objectives	**Strategies**	**Measures**
Maximize resources and capacity to assist individuals with disabilities in achieving gainful employment	• Replace DVR funding for mental health Clubhouses • Implement a supported employment pilot project	• Increase the number of consumers showing positive outcomes in the areas of: employment, independent living, social connectedness, substance use. Activities: C069 MH Services – Other Community Programs

Goal: USE EFFECTIVE TREATMENT TO ENHANCE OUTCOMES		
Objectives	**Strategies**	**Measures**
Provide treatment alternatives to incarceration	• Implement drug sentencing reform by working with local authorities to provide substance abuse treatment in lieu of incarceration • Support judicially supervised treatment models such as Drug Courts to promote public safety and reduce re-arrests among nonviolent, chemically dependent offenders	• Number of individuals that accessed treatment in lieu of incarceration • Number of re-arrests among nonviolent offenders who participated in judicially supervised treatment models
Improve capacity to house forensic patients at the state mental hospitals	• Add a 20 bed forensic ward at Eastern State Hospital, and a 40 bed forensic ward at Western State Hospital	• Reduce waiting list Activities: C063 MH Services – State Psychiatric Hospitals
Strengthen care coordination to improve health status and moderate health expenditure growth rates	• Implement predictive modeling to determine the most effective treatment for the 5% of clients who account for close to 50% of the health care costs • Implement intensive pharmacy benefits management • Along with DOH, HCA and other agencies, implement the Governor's directives for preventive care, chronic care management and health technology • Reduce disparities in health outcomes, particularly for ethnic minorities • Work with DOH on the definition and implementation of 'medical homes,' particularly for the aged, blind and disabled	• Growth rates in per capita costs for children, families, disabled and aged populations • Growth rates in pharmacy costs and pharmacy utilization • Joint recommendation to the Governor on preventive care, chronic care management and health technology • Complete proposal for definition of medical homes Activities: H056, Mandatory Medicaid Program for Children and Families H057, Medicaid for Optional Children H058, Medicaid Program for the Aged, Blind and Disabled H060, Medical Care for General Assistance Unemployable and ADATSA

Goal: USE EFFECTIVE TREATMENT TO ENHANCE OUTCOMES (cont)		
Objectives	**Strategies**	**Measures**
Standardize practice of early screening, assessment, and referral to services	• Collaborate with other programs serving children, youth and adults to screen for co-occurring mental and substance abuse disorders and link with integrated treatment • Provide training and consultation to primary care providers so they can screen for mental and substance abuse disorders and connect patients with treatment and supports (HRSA) • Evaluate the implementation, impact, and effectiveness of the new screening instrument for co-occurring mental health and substance abuse disorders mandated under SB 6793 • Implement a crisis intervention team to train police force on how to interact with the mentally ill • Provide training and consultation to primary care providers regarding screening and diagnosis of mental health conditions. • Provide expanded Gatekeeper programming as an outreach to older or isolated individuals who may benefit from behavioral health screening. • Implement a comprehensive screening process to promote early intervention and treatment for people with mental disorders.	• Increase the number of consumers receiving an integrated mental health and substance abuse screen • Increase the number of people receiving outreach services while transitioning from jail or prison to the community • Increase the number of primary care providers who receive training on mental health diagnosis and treatment. • Increase the number of older adults receiving mental health services. Activities: C017, Mental Health Services – Medicaid Managed Care C018, Mental Health Services – Non-Medicaid Recipients C069, Mental Health Services – Other Community Programs C071, Mental Health Services – Expanded Community Residential and Support Services for Older Adults C072, Mental Health Services – Dangerously Mentally Ill Offenders C073, Mental Health Services to Jails – Facilitating Access Services
	•	

Goal: REINFORCE STRONG MANAGEMENT TO INCREASE PUBLIC TRUST		
Objectives	**Strategies**	**Measures**
Improve financial planning and oversight	• Add staff in MHD headquarters for audit, compliance, monitoring, and consumer response	• Financial oversight of community program passes federal audit Activities: C069 MH Services – Other Community Programs
Comport with federal eligibility requirements	• Implement processes necessary to verify citizenship of all Medicaid clients applying for or continuing to receive benefits • Restructure the alien emergency medical (AEM) program	• Reduction in audit findings relating to eligibility or services to non-citizens Activities: H056, Mandatory Medicaid Program for Children and Families

Goal: STRENGTHEN DATA-DRIVEN DECISION MAKING		
Objectives	**Strategies**	**Measures**
Expand the use of evidence-based medicine in coverage and medical necessity decisions to improve outcomes	• Publish a website to improve client and provider understanding of evidence-based coverage and medical decision criteria • Collaborate with other state agencies in technology assessment (SHTAP) and common decision criteria • Initiate an MHD/HRSA Institute with expertise on effective evidence based practice services and implementation	• Reduction of unsafe, high-cost and ineffective therapies, devices, procedures, and drugs in state purchased health care services • Track and trend approval, denial and fair hearing activity related to evidence- based decisions • Track and trend cost, morbidity and morbidity improvements using evidence-based medicine • Joint recommendation on SHTAP Activities: H056, Mandatory Medicaid Program for Children and Families H057, Medicaid for Optional Children H058, Medicaid Program for the Aged, Blind and Disabled H060, Medical Care for General Assistance Unemployable and ADATSA
Expand and leverage information technologies	• Implement ProviderOne system to increase data driven program management capacity • Use health technology to improve access and coordination of mental health care, especially in remote areas or underserved populations • Develop and implement integrated electronic health record and personal health information systems • Implement electronic medical records at the state mental hospitals, which will be a system for patient billing to increase revenue	• Completion of a project plan to transition all three state hospitals to electronic medical records • Increase the number of RSN and committee meetings using video conferencing Activities: C063 MH Services – State Psychiatric Hospitals C069, Mental Health Services – Other Community Programs C900, Mental Health Services – Program Support • ProviderOne implementation complete Activity: H001, Administrative Costs

Goal: VALUE AND DEVELOP EMPLOYEES		
Objectives	**Strategies**	**Measures**
Improve skills and understanding in the workforce	• Improve completion rate of mandatory trainings, including Diversity training • Broadly promote trainings that meet the DSHS training requirements	• Percentage of individuals who have completed mandatory trainings as measured on a quarterly basis Activity: H001, Administrative Costs
Improve the workforce profile of under-represented groups	• Identify training and professional development opportunities for staff to advance their knowledge, skills and abilities.	• Participation and satisfaction of staff in training and development opportunities. • Ability of staff to implement what was taught. • Satisfaction of supervisors based on employee's PDP evaluation. Activity: H001, Administrative Costs

Goal: IMPROVE INTERNAL AND EXTERNAL PARTNERSHIPS		
Objectives	**Strategies**	**Measures**
Improve our ability to measure race/ethnicity so that HRSA can target interventions appropriately	• Collect information on race/ethnicity of TXIX clients • Collaborate with community–based organizations and academic researchers who can help find out more about disparities in patients and how to eliminate them • Use contractual agreements with health plans to measure and eliminate disparities (quality improvement aspects of the contracts) • Work with the Economic Services Administration to develop better ways to identify ethnicity in ACES/ProviderOne • Use community partners to learn more about how to overcome perceptions and ultimately improve health outcomes	• Reduction in the percentage of 'race unknown' clients in ACES • Identify one service or disparity in one or more specific populations by January 2008 • Initiate program to reduce identified disparity by July 2008 Activities: H056, Mandatory Medicaid Program for Children and Families H057, Medicaid for Optional Children H058, Medicaid Program for the Aged, Blind and Disabled

Chapter 5 ● Performance Assessment

Government Management Accountability and Performance

GMAP provides the structure to maintain focus on Priorities of Government and the Governor's goals. Regular reporting, internally and externally, keeps the administration's priorities and performance visible at all levels – executive management, staff and stakeholders.

Policy implementation and reporting teams have been formed to facilitate a systemic approach to accountability and performance. Cross-administration teams may link with outside agencies and other stakeholders to assure there are no unintended consequences during implementation. Structuring implementation correctly also assures effective use of state resources.

During the strategic planning period, all state agencies will be dealing with four major reporting initiatives:

- Priorities of Government, which is budget-driven
- GMAP, which reports on key decision-making
- Performance audits, which are retrospective reviews
- Baldridge or WSQA assessments, a systemic quality review

The administration will continue to rely on the Governor's GMAP and health policy staff throughout the coming years, to help us consolidate or streamline these four activities.

Other Performance Reviews

The three state hospitals are accredited by the Joint Commission on Hospital Accreditation. As part of their accreditation process they undergo a thorough independent review of their clinical care, quality improvement and business processes. In addition, Child Study and Treatment Center partners with the local IOC to participate in an annual review of their program.

HRSA measures the performance of the contracted managed care organizations providing health care. The health plans are required to report on Health Plan Employer Data and Information Set (HEDIS) measures, such as vaccinations for children, as well as conduct a satisfaction survey of clients receiving services from the plans.

Closing Performance Gaps

The implementation of ProviderOne will close a significant performance gap currently existing in the management of Medicaid. The following are currently existing critical business issues that ProviderOne is meant to assist in resolving:

- Current system does not meet business needs. The systems architecture prevents it from being easily modified to respond to policy and program changes, and lacks ready access to data for critical reporting, analysis and decision support activities.
- High costs for modification to respond to rapid changes in supporting systems. Because of the technology used, changes require code modification.

- Poor ability to interface with other systems. Interface options are limited due to the overall system design.
- Bringing critical data together. Current MMIS environment allows for Medicaid payments and/or data from multiple sources. Consolidation increases the ability to manage and report on the entire Medicaid program. Further, a newly designed architecture will allow for consolidation of other authoritative data sources (such as CMS EDB and DOH vital statistics data) to enhance payment and data accuracy.
- The limited support of digital government and e-business initiatives. The current system technology does not easily interact with recent technologies needed to provide e-business type services.

Also, with ProviderOne, the agency may develop better ways to track clients receiving services from multiple divisions or other agencies. Continuity of care can make a significant difference in health outcomes.

HRSA, with other agencies such as the Health Care Authority and Labor & Industries, has started to study the possibilities of expanding the use of evidence-based medicine. The goal is to achieve the best health outcomes for clients, and spend taxpayer dollars as efficiently and effectively as possible. Eventually, it may be decided that some services that are currently not covered would be added. This may be broadened to include behavior management, prevention and other treatment modalities, not just acute physical care. The Deficit Reduction Act of 2005 grants states some flexibility in program design, which may also help in this endeavor.

The chronic care management program will start with pilot projects in select communities and a statewide overarching contract serving targeted populations and using predictive modeling.

Prior reductions in services may need to be revisited. Adult dental care was reduced by approximately 25% when the state was facing lean fiscal times during the post-September 11 recession. Failure to prevent dental problems can lead to pain and infection, which can exacerbate existing chronic health conditions. HRSA will look at restoring prior dental care budget reductions and expanding access to dental services.

The Mental Health Transformation Grant and the Governor's Blue Ribbon Commission are only two of the opportunities for the HRSA to look at the service delivery system from a much broader perspective, with an emphasis on positive outcomes such as recovering physical wellness, sobriety, and mental health. These entities will look at the long-term challenges facing the State, and provide a framework for the future of health care for its citizens. In the meantime, the agency will consider ways to emphasize wellness, prevention and recovery, rather than emphasizing the historic medical model of dependence on the treatment of symptoms.

Chapter 6 ● Internal Capacity Assessment

WORKFORCE AND ORGANIZATIONAL CAPACITY

The Health and Recovery Services Administration is committed to the continued development of its workforce capabilities in order to meet our strategic goals for the next biennium. This commitment is necessary in part because of the significant organizational changes that occurred during the 2005-2007 biennium, including the creation of a new administration as a result of a merger of seven divisions from the Medical Assistance Administration, the Division of Alcohol and Substance Abuse, and the Mental Health Division. In addition to the merger, other identified organizational changes include the need to develop and implement a shared services model in a number of critical areas, including information technology, human resources, workforce development, and budget and fiscal disciplines. By creating a shared services model, HRSA will help create interdependence in decision making, and create a system for more efficient and effective delivery of services.

HRSA's workforce and organizational capacity has changed and will continue to evolve for the next biennium. As a result of the merger, we now have a workforce of more than 3500 FTEs including both represented and non-represented employees, WMS employees, health care professionals, and exempt positions. This has created unique difficulties in terms of filling vacancies. Recruitment and retention will be an ongoing challenge for HRSA particularly within the three state mental health hospitals and with DASA drug and alcohol counselors. DASA and the state hospitals recruit staff in a variety of professional disciplines that require licensure or certification (i.e. physicians, occupational therapists, physical therapists, nurses, social workers, dietitians, pharmacists, and drug and alcohol counselors). The pool of available candidates in many of these professions is low, and DASA and the hospitals are challenged to compete successfully with other employers for quality employees.

Contributing to the challenge of recruiting and retaining a talented workforce for HRSA are the competitive wages and incentive packages offered by private sector organizations. This is also true to a lesser degree in other agencies outside of the Department of Social and Health Services. Current employees are often recruited by other agencies where the pay is higher and the number of responsibilities is significantly lower. The challenges of recruiting and retaining employees in such an environment require creative thinking and a comprehensive strategy so that the needs of our clients continue to be met.

The organizational development needs of our workforce are ongoing. It is important to provide training and development opportunities for all employees which meet agency, certification/licensure requirements and encourage personal/professional growth. Our program managers need the tools to adequately meet the expectations for their positions (i.e. contract management/monitoring). We must also focus our efforts on leadership development in order to ensure that we have sufficient numbers of qualified candidates for future leadership positions.

Current and future employees will be challenged by the significant changes facing the Health and Recovery Services Administration. These changes include the co-location of staff from six buildings into one building into the Cherry Street Plaza. The co-location will make the Administration more efficient and effective, but will also require development opportunities related to business processes, a new work environment, and change management. Likewise, the implementation of ProviderOne will mean changes to business processes, the organizational structure, policy and procedures, skills and competencies, and significant changes to the culture itself at HRSA.

TECHNOLOGY CAPACITY

The current trend of increased reliance on information technology capacity and capability will continue and likely increase. This will manifest itself by a continuing need to increase capabilities with the local and wide area network and application infrastructure across the administration. Drivers include the implementation of the ProviderOne system (which will replace the current MMIS) and implementation of electronic medical records (EMR) as defined in the Governor's health initiatives. EMR will also drive needed enhancements in our institutions' technology infrastructures, especially for Western and Eastern State Hospitals. In addition the increased proactive approaches used to manage programs will force accelerated integration and interoperability with systems not only across administrations within the department but also with community stakeholders and other government authorities. These activities will drive many changes in how technology is used all the way down to the desktop, and will require new and innovative use of tools and techniques.

Enterprise Architecture has played a very successful role with DSHS and HRSA and will continue to be a focus in the future. HRSA will be working very closely with the State and the Department's Enterprise Architecture Program to help facilitate the goals of the administration and DSHS.

FINANCIAL CAPACITY

Throughout the nation, health care costs are increasing overall. During 2003 and 2004, health care costs increased an average of 8.1% in the nation, by 8.5% in Washington State and by 4.9% in the Medicaid program for Washington State. This increase requires additional resources from the State treasury as well as more funding from the federal government. The increase has caused Congress to consider significant reductions and changes to the Medicaid program, to ensure that the program is sustainable into the future.

A major area of reduction in federal participation is the elimination of Intergovernmental Transfers (IGT). This change alone would have cost the State $80 million per year if there had been no mitigation. In addition to the IGT elimination, the federal government has actual or proposed limitations on funding in several programs, including the Disproportionate Share Hospital (DSH) program, supplemental payments to providers, Certified Public Expenditures (CPE), Alien Emergency Medical program and funding for mental health services under the State's waiver. These limitations will place additional pressure on the State and on providers who rely on the Medicaid program to maintain the health care safety net. Implementation of the new Medicare Part D is also increasing state costs at mental health institutions and through the clawback calculation. Congress is considering additional cuts to Medicaid which may place further pressure on state funding for the program.

HRSA is receiving additional funding in certain areas, mainly additional federal grants for Alcohol and Substance Abuse treatment, and a transformation grant for mental health programs and services.

At the State level, HRSA is experiencing continued pressure to increase savings, primarily through new initiatives aimed at controlling costs for all state level health care programs (e.g. L&I, HCA and Medicaid). These initiatives include evidence based medicine, expansion of substance abuse treatment funding and new managed care initiatives.

Finally, administrative resources continue to be stretched as additional monitoring, review and audit, and programmatic documentation requirements are placed on HRSA through State Auditor, federal and legislative requirements.

SERVICE DELIVERY CAPACITY

HRSA faces some rather complex service delivery challenges. Historically, DASA has had very limited capacity to serve clients on demand, and MHD has been required by the legislature to close wards in the state hospitals as a result of budget reductions. DASA is now expanding capacity under a legislative mandate, and MHD is opening wards as the result of a lawsuit. Medical Assistance has studied capacity for physician services and, while there are pockets throughout the state where access may be an issue, clients appear to be receiving needed care.

There is a full range of issues that will impact DASA's ability to ensure the provision of quality chemical dependency prevention, intervention, and treatment services.

Even prior to the treatment expansion authorized under HB 5763, there were regional shortages of chemical dependency professionals (CDPs), particularly in rural areas and in treatment agencies serving diverse ethnic and racial populations. CDPs are being hired away from community treatment agencies to take jobs in schools, and criminal justice and mental health agencies. Through its staffing survey, DASA monitors staff diversity at certified treatment agencies. While there have been significant increases in the percentage of the racial and ethnic minority counselors, these percentages are still below those of patients served. With the major expansion of treatment authorized by the Legislature, as well as the increasing demand for CDPs by schools and social service agencies, and in the prevention field, the shortage of CDPs is likely to become both more widespread and more acute. They will also be increased demand for providers who can deliver treatment services for elderly, medically compromised, and disabled patients.

Both the Washington State Brief Intervention, Referral, and Treatment (WASBIRT) and Access to Recovery (ATR) programs are federally funded, and time-limited. Without additional funding once the grant periods are over, DASA will no longer be able to provide the intervention and support services currently facilitated by the grants.

DASA's prevention system has changed significantly in the past five years, and the pace of change is likely to accelerate. There is increased emphasis on the use of evidence-based programs and practices, the evaluation of locally based prevention efforts, and a new six-year county-based planning process. There are new grant programs and initiatives focused on underage drinking. At the same time, any reduction in federal support for the Safe and Drug Free Schools Program could place some of the gains made in maturing prevention approaches and programs in jeopardy.

A new problem/pathological gambling program has been created to serve the needs of gamblers and their families. Many problem/pathological gamblers have co-occurring mental health and substance abuse problems. Current levels of funding fall far short of meeting the need for intervention.

MHD received $20 million in the 2006 supplemental budget to create PACT teams, develop an implementation plan to increase housing for persons with serious mental illness, open wards in the state hospitals and strengthen utilization review for

community and state hospital usage. In the case of Pierce County s. State of Washington, a Thurston County Superior Court ruled that the state psychiatric hospitals must immediately accept custody of persons upon their commitment to involuntary treatment of 90 days or longer. In light of this ruling, funding should be provided for temporary additional capacity that was added during October through November 2005, and to develop additional options for hospitalization that can be based in the community.

In March 2003, HRSA developed and began tracking a set of measures to monitor HRSA's fee-for-service (FFS) access to physician and ARNP (nurse practitioners) care to medical programs administered by HRSA. These measures are:

1. Number of active FFS providers, which provides a basic measure of physician participation;

2. Capacity of the FFS providers network presented as a ratio of providers to 1,000 clients, which provides a normalized measure of access capacity; and,

3. Distribution of FFS visits performed by the top quartile of active providers, which provides a measure of workload across active physicians.

The number of "active" FFS providers is compared with the reported number of Medicaid Healthy Options (HO) managed care, state employees' PEBB managed care and state employees' Uniform Medical Program (UMP) providers to assess if there is a comparable loss or gain in physicians serving HO, PEBB and UMP members.

The three measures are separately compared for FFS primary care and specialty care providers, and for adult and children providers. Primary care providers are defined as those who were in the following four categories: general practice, family practice, pediatrics, and internal medicine. Specialty care providers are those who were outside the four categories.

Each measure is compared on a statewide and by-county basis to identify overall trends and specific county issues. The measures are updated every six months on a January/June cycle. To ensure complete data, there is a six month lag in generating the data used for the most current periods.

To better assess the burden on providers, two additional measures are being added. These measures are - visits per active provider and visits per 1,000 clients. Visits per provider will indicate whether providers are on average providing more services to Medicaid clients. Visits per 1,000 clients are a utilization measure that will indicate whether providers are seeing clients who are using more services. These measures are being tracked on a quarterly basis beginning July 2003.

Overall, calendar year (CY) 2004 statewide data continued to show sustainable trends. However, specialty providers in certain counties had reductions that will continue to be monitored. While physician and ARNP participation has increased, 70% of office visits are still provided by only 25% of the active providers.

The number of active providers increased 3.8% from an average of 13,247 in SFY 2003 to 13,746 in SFY 2004. This is a continuation of a trend over the past seven years (1998 through 2004) in which provider participation increased an average of 3.0% per year. The Administration will continue to monitor access to physician services every six months.

Appendix 1 ● Statutory Authority

Federal Statutes:
Title II, XIX and XXI of the Social Security Act [Title 42, U.S. Code (USC)}

Federal Rules and Regulations:
Titles 20 and 42 Code of Federal Regulations (CFR)

State Constitution
Article III (Creation of Executive Departments); Article XIII (Provisions regarding protection of vulnerable populations); Article XX (Provisions regarding public health, medicine and drugs).

State Statues
- **Chapter 10.05 RCW:** Deferred prosecution statute
- **Chapter 10.77 RCW:** Procedures for court actions involving the criminally insane.
- **Chapter 38.52 RCW:** Emergency management and disaster relief
- **Chapter 18.205 RCS:** Defines the state certification requirements for chemical dependency professionals (CDPs).
- **Chapters 43.17.120 and 43.17.130:** HRSA's designation as the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) disability determination agency for the state.
- **Chapter 43.20A.890 RCW:** Establishes a program for the prevention and treatment of problem and pathological gambling.
- **Chapter 46.61.5056 RCW:** Driving under the influence (DUI) violators – evaluation and treatment
- **Chapter 70.96A RCW:** Alcoholism
- **Chapter 70.96B RCW:** Treatment for alcoholism, intoxication and drug addiction – pilot programs
- **Chapter 70.96C RCW:** Screening and assessment process for chemical dependency, mental disorders, and co-occurring disorders
- **Chapter 71.05 RCW:** Mental illness -- provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.
- **Chapter 71.24 RCW:** Establishes county-based regional support networks.
- **Chapter 71.32 RCW:** Mental health advance directives.
- **Chapter 71.34 RCW:** Mental health services for minors.
- **Chapter 72.23 RCW:** Psychiatric state hospitals.
- **Chapter 74.04 RCW:** Medical assistance program's miscellaneous authority
- **Chapter 74.09 RCW:** Enabling statute for the Medical Assistance Program
- **Chapter 74.09A RCW:** Coordination of benefits provisions of Medical Assistance
- **Chapter 74.50 RCW:** Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)

Appendix 2 ● Client Data

Clients in August 2005

Medical & Mental Health

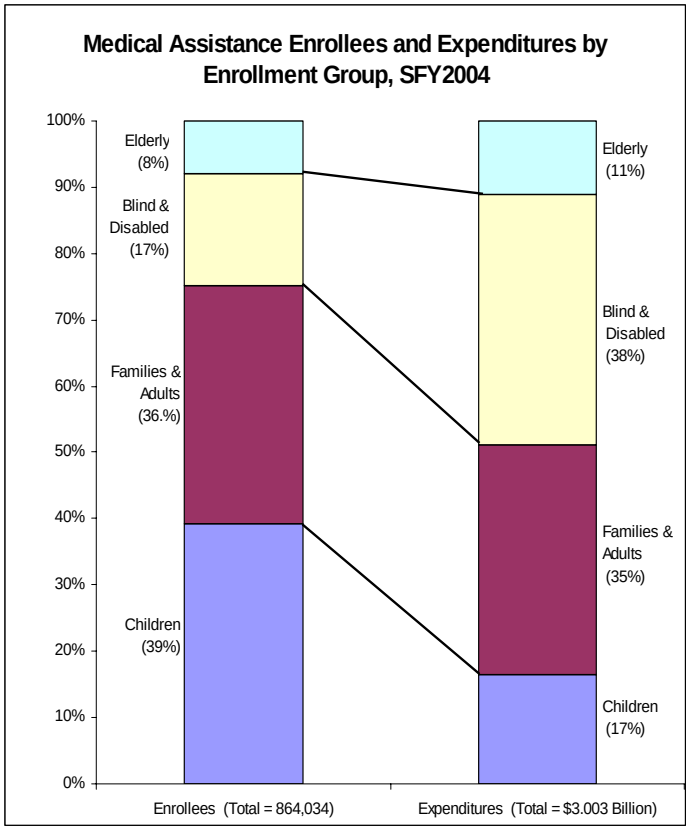
Medicaid/SCHIP Clients – full scope of care	876,745
Family Planning Only (95% Medicaid)	115,478
State Medical Clients	15,979

Drug & Alcohol

Prevention*	9,888
Treatment*	18,948
Detox*	1,137

Total HRSA	**1,038,175**

*Some of these clients may also be receiving medical care and/or mental health treatment.



Appendix 3 ● Survey Questions

The questions asked were:

- Relationship to DSHS: How would you describe yourself?
  - Provider
  - Client/Family
  - Stakeholder
  - Vendor/Supplier

- Which area of HRSA do you deal with? (All that apply)
  - Community mental health
  - Medical assistance fee-for-service
  - Medical assistance managed care
  - State hospitals
  - Pharmacy
  - Medical equipment and supplies
  - Substance abuse prevention and treatment

- What is the most important thing we can do to improve the health of Washington residents?
  - Improve access to care
  - Focus on education and prevention
  - Create incentives that help clients adopt healthy lifestyles
  - Apply evidence-based practices across all services
  - Other

- How would you contain costs if budgets were severely limited?
  - Expand preventive services
  - Reduce caseloads to protect the most vulnerable clients
  - Cut optional benefits such as adult dental or adult vision
  - Reduce the basic benefits package
  - Other

- How well do you think we work with other state agencies and community programs?
  - Average
  - Needs work
  - Good
  - Poor
  - Excellent

- How can we expand our partnerships with health care providers to improve access and coverage in all parts of Washington State? (All that apply)
  - Involve provider-partners in decision making
  - Increase rates
  - Contract with additional providers
  - Narrow benefit packages
  - Other

- What are the top three changes you would make in state-sponsored health care coverage, mental health services or substance abuse treatment at DSHS?
  - Stakeholders were allowed to list up to three suggestions.

Appendix 4 ● Stakeholders Input

Title 19 Committee Additional Areas of Concentration for Strategic Plan

HRSA's draft Strategic Plan is an excellent start in developing a work plan for 2007-09. Upon review, the Executive Committee proposes for Committee discussion the following recommended additions to the HRSA Strategic Plan, to be used in budget planning and prioritization.

1. **Improve continuity of coverage and care for Washington residents.** DSHS and the Health Care Authority need to do better at creating seamless transitions among the various public programs. Especially when a person is receiving care through multiple agencies or divisions of agencies, or needs to receive ongoing care from a sequence of agencies, systems need to be put in place so that care is not interrupted and gaps in coverage are reduced or eliminated.

Examples:

- As clients become ineligible for Medicaid, for example children who reach the Medicaid maximum age, assist them in a smooth transition to Basic Health.
- Consider changes to the Medically Needy program and to Medicare Part D state wraparound coverage in order to promote continuity of coverage

2. **Focus services on recovery.** Health outcomes should be a key measurement of HRSA's success. Where it is possible to enable a person to recover, expenditures should focus on that outcome rather than on promoting medical dependency. HRSA has taken great strides in that direction with drug and alcohol treatment initiatives. These should be continued and extended to mental health treatment and other areas. However, we do not mean this focus to be at the expense of treating people with degenerative conditions or needing palliative care or maintenance care to prevent the worsening of conditions.

Example: The President's Commission, Washington's Governor, DSHS Secretary, the Legislature, and the Transformation Grant all have made public commitments and allocated funding for the promotion of resilience and recovery. Models that should be implemented here include Program for Assertive Community Treatment (PACT), Fountain House, and Rose House.[1]

[1] **PACT** is a program in which teams, consisting of MD, RN, Vocational Rehabilitation, and Care Manager, meet daily regarding coordinated care for each client. Started in Madison, WI , it boasts a 52% employment outcome (in contrast to WA with 9%). **Rose House** in Tacoma is based upon the principles of **Fountain House** in New York City. It was founded almost half a century ago in response to the waves of people who were being "discharged to the streets" from state psychiatric hospitals. It's programs require clients to become actively involved in their own recovery. Everyone must "pull his or her own share of the load." It now is a huge facility with social events, training classes, contracts with numerous employers and industries. The facility is run almost entirely by consumers who are in recovery from mental illness/substance abuse or both. Both of these programs or variations on their themes exist all over the country-- but are few in number despite their long-standing track record of success.

Both approaches are based upon the expectation of Recovery and Personal Responsibility.

3. **Improve coverage and access to dental care - a key preventive measure that desperately requires attention.** The Adult Dental program remains funded at 75% of its former level. These cuts mean that many DSHS clients deal with pain, infection and malnutrition on a long-term basis. Medicaid covers very little in the way of restorative work; removal of teeth is often the only option. In addition, there are very few dentists who will accept Medicaid, let alone those who will accept Medicaid and do specialized dental treatments. Consequently, clients go without dental care or at best, must wait many months or years for treatment.

Dental coverage is particularly important for people with diabetes, an illness that is often associated with obesity. The preliminary Health Priorities of Government prioritize addressing obesity. DSHS should prioritize the prompt treatment of persons with dental conditions that aggravate obesity and other chronic medical conditions. It is critical to prevent deterioration of oral health, which can quickly aggravate general health status; untreated dental infection becomes systemic infection.

> Example: 40 year old woman with diabetes had dental pain in upper molars. The community clinic determined she needed 5 root canals, but these are not covered by Medicaid. Her choices were to pay up front for the treatment (over $1100), have the teeth pulled, or continue getting temporary treatment which did not resolve the problem. She could not afford to pay for root canals, so she received the temporary treatment for a number of months. Eventually each of the teeth had to be pulled over a 5-month period, due to severe infection. The treatment involved 32 dentist appointments and 12 emergency room visits. During this period, her dental problems and infection had an extremely negative impact on her ability to eat, further complicating the diabetes and causing an increase in blood sugars.

4. **Revisit non-covered services to allow coverage of medically necessary evidence-based care.** Now that the state is turning toward evidence-based treatment criteria, it is becoming less necessary to exclude entire coverage categories. If the goal is improvement in clients' health status and eventual recovery, the focus should be on potential health outcomes for patients based on "what works" rather than what's on a list of covered services.

> Example: There are many Medicaid enrollees who need behavioral health support services, but for whom these services are not covered. There is good medical evidence to support this treatment. However, only those patients who represent a risk to themselves or the community are permitted to access these services. Other clients should also be able to access them, either through a community mental health agency or an alternate service provider. These services are covered in most states.

Appendix 5 ● Institutional Facility Plans

Future Capital Needs in the Division of Alcohol & Substance Abuse

The Division of Alcohol and Substance Abuse has demonstrated through research the value of public funded chemical dependency treatment in reducing criminal behavior and acute medical/psychiatric costs. As funds become available to expand treatment access, it is becoming increasingly difficult to attract contractors to provide residential treatment services. DASA pays providers deeply discounted rates and, as is the case with private insurance, we only pay after the services are provided. This means the contractor must make a substantial investment in facilities that meet Department of Health and DASA standards, in addition to operating costs, in order to obtain a state contract. Community resistance to siting such facilities exacerbates these problems. Gaining community and local government support for new facilities may subject contractors to costly delays.

One approach to dealing with these difficulties would be for DASA to acquire buildings to be used by alcohol and drug treatment programs. These facilities would be owned by DSHS but program operations would be contracted out to independent service providers.

Capital Needs in the Mental Health Division for 2007-2009

A STRATEGIC OVERVIEW

Program Discussion

The Mental Health Division administers an integrated mental health system promoting client recovery while ensuring the safety of both the individual and the community. The MHD mission is to ensure that people of all ages experiencing mental illness can better manage their illness; achieve their personal goals; and live, work and participate in their community.

The mental health system serves clients in community settings and State owned and operated hospitals. The community mental health system operates under a managed care model. Fourteen Regional Support Networks (RSNs), provide inpatient and outpatient services to both Medicaid and non-Medicaid eligible clients (approximately 130,000) and three psychiatric hospitals operate as clinical centers for the most complex public mental health consumers as mandated by the Mental Health Reform Act of 1989 (SB 5400). They are: Western State Hospital (WSH, 700 beds), Eastern State Hospital (ESH, 275 beds) and the Child Study & Treatment Center (CSTC, 47 beds).

Nearly three quarters of the state hospital patients are admitted pursuant to a civil court

order (RCW 71.05). Civil commitment orders are issued by a local superior court from a petition by County Designated Mental Health Professionals. One-quarter of the hospital population is committed under criminal process (RCW 10.77).

The 2007-2009 goals of the MHD's Strategic Plan and related MHD Capital Administration strategies include the promotion of services delivered in community settings and the establishment of the appropriate use and capacity of state psychiatric hospitals.

Future Challenges

The Mental Health Division faces several key challenges in the years ahead that will have impacts upon institutional facilities:

1. Achieving the Promise: Transforming Mental Health Care in America.

In 2002, the President announced the creation of the New Freedom Commission on Mental Health. In 2005, Governor Christine Gregoire announced Washington State's "Partnerships for Recovery", our plan for meeting the President's New Freedom commission challenge. Washington State was subsequently one of only eight states awarded federal funding for this effort. In announcing the plan, the Governor stated:

> "It is our vision that all people in the State of Washington who experience mental health challenges will lead happy, productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. The Transformation of mental health services in Washington State's "Partnerships for Recovery" will fundamentally change the way mental health care is provided and the way mental illness is perceived. State and local government will be accountable to consumers and families for cultural competence and service outcomes. The new mental health system will be consumer-driven; mental health will be understood as an essential element of overall health, and as a condition from which people can and do recover."

2. Pierce County lawsuit.

The September 2005 Superior Court rulings in the Pierce County lawsuit significantly increase the State's challenges to effectively manage RSN utilization of state hospital beds. Other RSNs have requested same treatment or threaten to sue. Western State Hospital has opened one ward and will need to open three additional wards over the next 16 months. Eastern State Hospital will need to open one ward over the next 16 months. There are potential statewide ramifications.

3. Continue to evolve toward a rehabilitation model.

SB 5400 requires state hospitals to continue to evolve toward a rehabilitation model as distinct from a medical model of treatment. New lines of psychotropic medications have enabled large numbers of patients to be discharged from the hospital and to participate more fully in therapeutic activities while in the hospital. In addition, the fundamental importance of access to various levels of indoor and outdoor activity - recreational, pre-vocational and vocational - is becoming increasingly more apparent in the speed of recovery and the permanence of improvement of hospitalized patients

4. Reductions in state hospital and community hospital bed capacity.

The MHD is still under a legislative mandate to reduce permanent bed capacity in the

state hospital system. Community psychiatric hospital beds have been in decline, reducing local resources for diverting state hospital commitments. MHD will continue its expansion of community services project and focus on the development of more community residential resources.

5. State hospitals must serve those patients considered too dangerous for community-based services.

SB 5400 also requires the state hospitals to serve the most complicated long-term care patients. Persons receiving care at these facilities show an increasing acuity due to physical and psychiatric impairments. This requires a higher staff to patient ratio, higher square footage space needs and increased space for on-site rehabilitation services. Two statutes passed in 1999 are expected to continue to increase the count of hospital patients likely to cause serious harm. SB 6214 encourages the courts to consider hospital commitment for a misdemeanant who has both a mental disorder and a history of inflicting serious harm. As a result of SB 5011, a prisoner in discharge process who has a mental disorder, chemical abuse problems, and a history of inflicting serious harm may be assigned to the state mental health system.

6. Assist in the establishment, preservation and renovation of mental health facilities.

In the 2005-2007 biennium, the Mental Health Division (MHD initiated a program to support RSN Community Based Care facilities. Projects ranged from significant funding for new evaluation and treatment facilities to preservation of existing systems. For 2007-2009, we are continuing this program. Our intention is to assist in the establishment of new or preservation of existing community mental health residential facilities.

The state hospitals are also a key component of the state mental health system. Preserving these assets, renovating them for current use, and re-fitting them for evolving need is a significant part of the program's capital administration.

7. Ensure the effective and efficient provision of ancillary or support services at the state hospitals.

It is important to ensure that the dietary, pharmacy, central supply, commissary, laundry, and plant maintenance services are upgraded from obsolete buildings to facilities that allow for efficient, effective and safe operations.

8. Address needs of developmentally disabled (DD) patients in residence.

The lawsuits concerning appropriate housing and treatment of DD persons at WSH resulted in Agreed Orders that mandate some physical separation, staff and rehabilitation efforts, and gender segregation in the forensic wards. Duplicate litigation at ESH is moving through the court system. The appropriate management of this population may require future facility changes.

9. Meet federal/state/county standards in an environment of changing clients and shifting funding.

As the state hospitals make changes in accordance with statewide program needs, mental hea care managers must continue their work to ensure that state hospital practice is in compliance with the expectations and requirements of federal and Joint Commission on Accreditation of Hospitals Organization (JCAHO) standards in order to maintain the federal portion of the hospitals' funding support as well as third party insurance. Federal clinical and facility surveys consider over-crowding to seriously deteriorate quality of care, and to be a basis for a revenue

This document is also available electronically at:
www1.dshs.wa.gov/strategic

Persons with disabilities may request a hard copy by contacting DSHS at: 360.902.7800, or TTY: 800.422.7930.

Questions about the strategic planning process may be directed to DSHS Constituent Services at: 1.800.737.0617.

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